1 General Provider and Participant Information

1.1 Provider Participation

1.1.1 Provider Participation Requirements

All providers wishing to participate in the Idaho Medicaid Program must complete a provider application packet. The packet includes a Medicaid Provider Enrollment Agreement that must be signed by the provider and returned with the enrollment packet to either EDS or the Department of Health and Welfare (DHW).

The provider must meet all applicable state and Idaho DHW licensure/certification and insurance requirements to practice their profession. In addition, the provider qualification requirements for the service(s) to be provided must be met. Information supplied will be used to validate credentials. Other certification/licensure and proof of insurance may be required as provided for in *IDAPA 16.03.09 Medicaid Basic Plan Benefits,* and *IDAPA 16.03.10 Medicaid Enhanced Plan Benefits*.

Continued provider participation is contingent on the ongoing maintenance of such licensure/certification and proof of insurance. The loss of or failure to renew the required license/certification and proof of insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

Additional information about the Idaho administrative rules is available on the Internet at: **www.accessidaho.org** and select: *Laws & Rules/Administrative Rules*.

1.1.2 Provider Responsibilities

Providers have the following ongoing responsibilities:

- To offer services in accordance with Title VI of the 1964 Civil Rights Act and Section 504 of the Rehabilitation Act of 1973, as amended.
- To review and abide by the contents of all DHW rules governing the reimbursement of items and services under Medicaid.
- To review periodic provider information releases and/or other program notifications issued by DHW.
- To be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with professionally recognized standards.
- To keep DHW advised of the provider's current address and telephone number.
- To sign every claim form submitted for payment or completes a Signature-on-File form (including electronic signatures).
- To acknowledge that Medicaid is a secondary payer and agree to first seek payment from other sources.
- To accept Medicaid payment for any item or service as payment in full and to make no additional charge for the difference.
- To comply with the disclosure of ownership requirements.
- To comply with the advanced directives requirement.
- To make records available to DHW upon request.
- Do not bill a Medicaid participant unless:
    - The participant is advised prior to receiving items or services and agrees to be responsible for payment.
    - The item or service is not covered by Medicaid and the participant is notified prior to receiving the item or service.
    - A third party payment was made to the participant, in which case the participant may be billed for an amount equal to that payment.

Services provided in excess of the Medicaid service limitations or not covered by Idaho Medicaid may be charged to the participant, if the participant is advised prior to receiving the service or item and agrees to be responsible for payment. Acceptance of the medical services beyond the limitations is the participant's financial responsibility.

1.1.2.1 Medical Record Requirements

Idaho Code Section 56-209h requires that providers generate records at the time the service is delivered, and maintain all records necessary to fully document the extent of services submitted for Medicaid reimbursement. This includes documentation of referrals made or received on behalf of Medicaid participants enrolled in the Healthy Connections (HC) Program.

Providers are required to retain records to document services submitted for Medicaid reimbursement for at least five years after the date of service.

1.1.3 Medicaid Provider Identification Numbers

1.1.3.1 Individual Provider Numbers

A unique, 9-digit provider number is assigned to the provider when the provider is approved to serve Medicaid participants. All Medicaid claims are processed based on this Idaho Medicaid provider number.

The 9-digit provider number consists of a randomly selected 7-digit base number followed by a 2-digit service location number. Providers with a single service location will have 00 as the 2-digit service location.

The National Provider Identifier (NPI) is part of HIPAA. The NPI number or numbers will replace existing provider numbers on electronic claims and will identify healthcare providers to health plans with a unique 10-digit numeric provider identifier. Based upon the federal NPI requirements, healthcare providers who have an NPI must use their NPI number for electronic claims and eligibility transactions.

- Providers must register their NPI(s) with Idaho Medicaid online at: **https://npi.dhw.idaho.gov**.

A provider enrolled in the HC Program as a primary care provider (PCP) receives a separate HC referral number to use when making referrals. See *Section 1.5 Healthy Connections (HC)*, for more information on using referral numbers.

1.1.3.2 Multiple Service Locations

A service location is defined as an office or clinic from which the provider renders services. A provider with more than one business address can have one 7-digit base provider number with multiple 2-digit service location numbers identifying where the service was rendered. Providers have the option of billing with the specific service location number, or can bill all services under their main service location number (00).

Some provider types must have a separate 7-digit base provider number for each location they provide services. These providers will have a single service location with (00) as the 2-digit service location.

1.1.3.3 Group Practice Provider Numbers

Many providers who offer services to Medicaid participants work within a clinic or group practice to share common business expenses, such as billing.

There are four types of group practices:

- Hospital affiliated.
- Partnership.
- Corporation.
- Corporate/partnership.

Form Available: Group and Individual Affiliation Rosters are included in *Appendix D; Forms*.

To accommodate these providers, a Medicaid provider number is issued to groups for billing purposes. Individual providers who are members of a group must be enrolled both individually and associated as a member of the group to bill Medicaid for services. In order to become affiliated as part of a group, the provider must complete the Group and Individual Affiliation Roster and return to Provider Enrollment for processing.

The Centers for Medicare and Medicaid Services (CMS) requires the identification of the individual who actually performs a service when billing under a group number. On paper claims, the performing provider's individual Medicaid provider number must be on the claim as well as the provider's group Medicaid number. On electronic claims, the performing provider's individual NPI number must be on the claim as well as the provider's group NPI number.

1.1.4 Signature-On-File Form

A provider or authorized agent must sign in the claimant's certification field on all claims. This is an agreement the provider makes to accept payment from Medicaid as payment in full for services rendered. The provider cannot bill the participant for an unpaid balance.

Providers must sign every claim form or complete a Signature-On-File form. This form is used to submit paper claims without a signature and/or to submit electronic claims. This form allows submission of claims without a handwritten signature. It is used for computer-generated, signature stamp, or typewritten signatures.

The Signature-On-File form remains on file at EDS and must exactly match the information in the claimant's certification field on the claim form. Never submit paper claims with the claimant's certification field blank. Enter Signature-on-File or have the provider sign in field **31** of the CMS-1500 claim form, field **62** on the ADA claim form, or field **23** on the Pharmacy claim form. Contact EDS Provider Enrollment for more information as indicated in, *Section 1.2 Services for Providers*. To bill electronically, it is necessary to complete a separate certification and authorization agreement.

Form Available: A Signature-On-File form is included in *Appendix D; Forms*.

If you believe that a particular Medicaid provider is abusing the program, you may contact:

Medicaid Fraud and Program Integrity Unit
PO Box 83720
Boise, Idaho 83720-0036
prvfraud@dhw.idaho.gov
Fax: (208) 334-2026

1.1.5 Provider Recertification

In accordance with state and federal regulations, DHW monitors the status of provider participation requirements that apply to each individual provider type. Continued licensure, certification, insurance, and other provider participation requirements are verified on an ongoing basis.

1.1.6 Provider Termination

The Department of Health and Welfare (DHW) is required to deny applications for provider status or terminate the Medicaid Provider Agreement of any provider suspended from the Idaho Medicare Program or another state's Medicaid program. The Department of Health and Welfare may also terminate a provider's Medicaid status when the provider fails to comply with any term or provision of the Medicaid Provider Agreement. This includes advising DHW or EDS of any changes in address or ownership.

Continued provider participation is contingent on the ongoing maintenance of current licensure, certification, or insurance. Failure to renew required licenses, certification, or insurance is cause to terminate a provider's participation in the Idaho Medicaid Program.

1.1.7 Surveillance and Utilization Review

The Surveillance/Utilization Review Subsystem (S/URS) is a statistical subsystem within the Medicaid Management Information System (MMIS) that is used to monitor the utilization patterns of participants and providers participating in the Idaho Medicaid Program.

The S/URS system produces reports that display exceptions to the norm for services of similar providers. When the provider or participant services deviate from the norm, the Medicaid Fraud and Program Integrity Unit investigates.

Sometimes a deviation can result from the normal care and treatment of a participant with an acute or unusual medical condition, but most often a deviation results from a misunderstanding of billing instructions.

1.1.7.1 Provider Program Abuse

The Medicaid Fraud and Program Integrity Unit may occasionally investigate to determine whether a provider is misusing Medicaid. A fraud analyst may visit the provider of the service to determine the cause of the problem. If appropriate, the provider may receive a warning letter.

Fraud analysts conduct random studies of provider payment histories to detect billing errors and over-utilization. They may perform on-site reviews of records to verify that services billed correspond to services rendered to the participant. In more serious cases, a provider may be suspended for a specified time period, terminated from participation in the Idaho Medicaid Program, or prosecuted.

1.2 Services for Providers

1.2.1 Overview

EDS is the fiscal agent for the Idaho Medicaid Program. The primary objective for EDS is to process Medicaid claims efficiently and accurately for Idaho Medicaid providers.

The EDS Provider Services Unit enrolls providers into the Idaho Medicaid Program and responds to providers' requests for information not currently available through MAVIS.

The EDS Provider Relations Unit helps to keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid.

1.2.2 Medicaid Automated Voice Information Service (MAVIS)

To maintain effective and continuous provider communication, EDS offers MAVIS. Providers can obtain detailed participant, provider, and claim information through MAVIS. This service lets Idaho Medicaid providers get fast, accurate information on:

- Participant eligibility, insurance coverage, and program restrictions.
- Procedure code inquiries.
- Claim status, last check amount, and date.
- Provider enrollment status.

Providers who use MAVIS will also need a 4-digit security code. The number is only used to access the telephone service. See *Appendix C; Medicaid Automated Voice Information Service (MAVIS),* for more information.

The Medicaid Automated Voice Information Service (MAVIS) is available 24 hours a day including weekends and holidays, except during scheduled system maintenance. Medicaid Automated Voice Information Service will inform the caller if the system is unavailable.

To access MAVIS or to contact EDS Provider Enrollment and other provider services contact:

EDS
PO Box 23
Boise, ID 83707-0023

The Medicaid Automated Voice Information Service (MAVIS) can be reached at: **383-4310** from the Boise calling area, or toll-free at: **(800) 685-3757**.
Provider representatives are available Monday through Friday (excluding state holidays)
8 a.m. - 6 p.m. MT.

1.2.3 Provider Enrollment

The Department of Health and Welfare (DHW) works with EDS Provider Enrollment to promptly and accurately enroll new providers in the Idaho Medicaid Program. This team effort ensures efficient Medicaid provider enrollment and claims processing for services rendered to Medicaid participants.

The entities that participate in some part of provider enrollment are:

- Medical Care Unit.
- Bureau of Developmental Disability (DD) Services.
- Bureau of Long-Term Care.
- Bureau of Facility Standards.
- Office of Medicaid Automated Systems (MAS).

- Regional Medicaid Services (RMS) (all regions).
- Mental Health and Substance Abuse.
- Pharmacy Unit.
- Family and Community Services (all regions).
- Developmental Disabilities (DD) Program (all regions).
- Healthy Connections (HC).
- EDS.

Some of these DHW entities approve the provider applications for specific provider types and specialties. The provider enrollment packets are reviewed by the provider enrollment team for completeness. Providers are enrolled by the processing of their application; using the information they provide to conduct a credentials investigation.

After the provider is approved for participation in the Idaho Medicaid Program, the provider information is entered into the computer system, a unique provider number is assigned, and the new provider is sent a complete billing package for Idaho Medicaid Program participation.

1.2.3.1 Provider File Updates

After enrolling, providers must notify Provider Enrollment, in writing, when there are changes in their status. The written notice must include the provider name and current Medicaid provider number. Status changes include:

- Change in address (or change in any other provider's address, if a group practice).
- New phone number.
- Name change (individual, group practice, etc.).
- Change in ownership.
- Change in tax identification information.
- Change in provider status (voluntary inactive, retired, etc.).

Note: The postal service will not forward mail or checks. All mail and checks will be returned to EDS.

A Change in Provider Information Authorization form is located in *Appendix D; Forms,* of this handbook and can be copied and used as often as necessary.

To change enrollment information or to apply for additional provider numbers, contact EDS Provider Enrollment.

1.2.4 Provider Service Representatives (PSRs)

EDS provider service representatives are trained to promptly and accurately respond to requests for information on:

- Adjustments.
- Billing instructions.
- Claim status.
- Participant benefit information.
- Participant eligibility information.
- Form requests.

- Payment information.
- Provider participation status information.
- Recoupments.
- Third party recovery information.

Provider Service Representatives: To contact an EDS provider service representative, call MAVIS and say *Agent*.

(208) 383-4310 in the Boise calling area

(800) 685-3757 (toll free)

Provider service representatives are available Monday through Friday from 8 a.m. - 6 p.m. MT (excluding state holidays).

When calling a provider service representative for questions about claims status, please have the following information ready:

- Billing provider's Idaho Medicaid provider number or National Provider Identifier (NPI).
- Participant's Medicaid identification number.
- Date(s) of service.

When calling a provider service representative for questions about participant eligibility, have the following information ready:

- Billing provider Medicaid identification number.
- Participant's name (first and last).
- Participant's Medicaid identification number, date of birth, or Social Security number.

1.2.4.1 Provider Handbooks

Providers can access an electronic copy of the *Idaho Medicaid Provider Handbook* from the DHW Web site at **www.healthandwelfare.idaho.gov**.

The online *Idaho Medicaid Provider Handbooks* are updated bi-annually. These updates are designed to keep providers informed of program changes and provide billing instructions. The most current version of the handbook is always available on the Internet.

The provider handbooks are intended to provide basic program guidelines, however, in any case where the guidelines appear to contradict relevant provisions of the Idaho Code or rules, the code or rules prevail.

1.2.4.2 Electronic Billing and Eligibility Software

Idaho Medicaid providers can receive electronic software developed by EDS that is HIPAA compliant. This software called Provider Electronic Solutions (PES) (provided by EDS at no cost) to Medicaid providers. It can be used for checking Medicaid eligibility and submitting professional, dental, institutional, and pharmacy claims.

Providers may also use vendor software, billing services, and clearinghouses. See *Section 2.2.1 Electronic Claims Submission*, for more information.

1.2.5 Provider Relations Consultants (PRC)

EDS PRCs help keep providers up-to-date on billing changes required by program policy changes implemented by the Division of Medicaid. Provider relations consultants accomplish this by:

- Conducting provider workshops.

- Visiting a provider's site to conduct training.
- Assisting providers with electronic claims submission.

For telephone, fax, and addresses for PRCs see the *Directory* at the beginning of this handbook.

1.3 Participant Eligibility

1.3.1 Overview

Medicaid is a medical assistance program that is jointly funded by the federal and state governments to assist in providing medical care to individuals and families meeting eligibility requirements. Income, resources, and assets are taken into consideration when determining Medicaid eligibility.

1.3.1.1 Eligibility Requirements

Applicants for Medicaid must meet each of the financial and non-financial requirements of the program in which they will participate. The Department of Health and Welfare (DHW) field offices determine Medicaid eligibility and enroll eligible applicants in the appropriate benefit package.

See *Section 1.3.3 Covered Benefits*, for more information.

1.3.1.2 Period of Eligibility

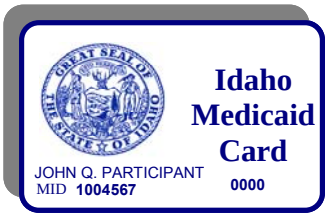
Participant eligibility is determined on a month-to-month basis. For example, a participant may be eligible during the months of April and June, but ineligible during May. It is strongly recommended that prior to providing services, participant eligibility be verified through Medicaid Automated Voice Information Service (MAVIS), Provider Electronic Solutions (PES), EDS tested vendor software, or point of service devices (POS). Medicaid only reimburses for services rendered while the participant is eligible for Medicaid benefits. Confirmation of eligibility is not available for dates in the future.

See *Section 1.3.4 Verifying Participant Eligibility*, and *Appendix C; MAVIS*, for more on MAVIS.

1.3.2 Medical Assistance Identification (MAID) Card

An identification card is issued when the participant is determined eligible for Medicaid benefits. All Medicaid participants, except ineligible aliens or presumptive eligibility (PE) participants, receive an identification card. Possession of a MAID card does not guarantee Medicaid eligibility. Providers should request the MAID card with additional picture identification and retain copies of this documentation for their records.

Sample Card



The participant's Medicaid identification (MID) number is on the card. It is a 7-digit number with no letters or symbols.

Note: Effective October 1, 2007, the Idaho Health Plan will replace the previous program titles Medicaid and SCHIP.

1.3.2.1 Medicaid Exception for Inmates

An inmate of an ineligible public institution can receive Medicaid while an inpatient in a medical institution. The inmate must meet all Medicaid eligibility requirements. Medicaid coverage begins the day the inmate is admitted and ends the day of discharge from the medical institution.

- A person is an inmate when serving time for a criminal offense or confined involuntarily in state or federal prisons, jails, detention facilities, or other penal facilities.
- An inmate is an inpatient when admitted to a hospital, nursing facility, intermediate care facility (for developmentally disabled)/mentally retarded (ICF/MR), or if under age 21, and is admitted to a psychiatric facility.
- An inmate is not an inpatient when receiving care on the premises of a correctional institution.

1.3.3 Covered Benefits

General information on services covered under the Idaho Medicaid Program are listed in the booklet, *Idaho Health Plan Coverage* which is available from the Division of Medicaid, Department Regional Offices, or on the Internet in English and Spanish.

See *Section 3 Provider Guidelines*, for specific service coverage and billing details for individual programs and specialties.

1.3.3.1 Medicaid Non-Covered Services

Prior to rendering services, providers must inform participants when services are not covered under Medicaid. Idaho Medicaid strongly encourages the provider to have the participant sign an informed consent regarding any non-covered services. If the participant chooses to obtain services not covered by Medicaid, it is the participant's responsibility to pay for the services.

See *Section 1.1.2 Provider Responsibilities*, for additional details.

1.3.4 Verifying Participant Eligibility

Providers should verify eligibility on the actual date of service, prior to providing the service. Eligibility information can be accessed four different ways. They are:

- PES.
- MAVIS.
- HIPAA compliant vendor software (tested with EDS).
- POS devices.

To obtain eligibility information from one of these systems, submit either the MID number or two participant identifiers from the following list:

- Social Security number (SSN).
- Last name, first name.
- Date of birth.

Participant eligibility information available includes Healthy Connections (HC) data, Medicaid special program limitations, certain service limitations, procedure code inquiries, third party recovery (TPR), Medicare coverage information, and lock-in data.

1.3.4.1 Eligibility Verification

EDS Software (PES): PES can be used to verify Idaho Medicaid eligibility. The software is HIPAA compliant and can be used to submit an ASC X12 270/271 (version 4010A1) eligibility request and response.

The provider may submit eligibility requests one at a time in interactive mode, or several at a time, which is called batch eligibility verification. Interactive eligibility requests are processed and eligibility status is returned within seconds. Batch eligibility verification requires additional time to process. Providers will be notified within 24 hours of a batch request in their submitter's Bulletin Board System (BBS) mailbox. The PES software can also be used for electronic claim submission.

For more information on eligibility requests, see the *Provider Electronic Solutions (PES) Handbook* available with the PES software.

MAVIS: Providers can use MAVIS to check participant eligibility. Eligibility information is available on:

- HC Program.
- Eligibility with special programs.
- Service limits.
- Prior authorization (PA).
- Other health coverage.

Users may request a fax copy of eligibility information that includes a confirmation number. See *Appendix C; MAVIS* for more information.

POS Devices: A POS device can be used to check participant eligibility.

Vendor Supplied Software: Providers may contract with a software vendor and use software supplied by the vendor. Software specifications are located on the Web at: **http://www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3348/DesktopDefault.aspx**. The specifications assist the vendor in duplicating the program requirements and allow providers to obtain the same information available with software supplied by EDS. All vendor software must successfully test with EDS before use.

Providers can check eligibility using vendor software, if the software is modified to meet the requirements of the HIPAA ASC X12 270/271, version 4010A1 format, and if the vendor successfully tests the transactions with EDS.

MedicAide newsletters are available on the Internet at:
www.healthandwelfare.idaho.gov/portal/alias__Rainbow/lang__en-US/tabID__3439/DesktopDefault.aspx

1.3.5 Participant Program Abuse/Lock-In Program

The Department of Health and Welfare (DHW) reviews Medicaid participant utilization to determine if services are being used at a frequency or amount that may result in a level harmful to the participant and to identify services that are not medically necessary.

Abuse can include frequent use of emergency room facilities for non-emergent conditions, frequent use of multiple controlled substances, use of multiple prescribing physicians and/or pharmacies, excessive provider visits, overlapping prescription drugs with the same drug class, and drug seeking behavior as identified by a medical professional.

To prevent abuse, DHW has implemented the participant lock-in program. Participants identified as abusing or over-utilizing the program may be limited to the use of one physician/provider and one pharmacy. This prevents these participants from going from doctor to doctor, or from pharmacy to pharmacy, to obtain excessive services.

If a provider suspects a Medicaid participant is demonstrating utilization patterns, which may be considered abusive, not medically necessary, potentially endangering the participant's health and safety, or drug seeking behavior in obtaining prescription drugs, they should notify the Pharmacy Unit of their concerns. The Department of Health and Welfare will review the participant's medical history to determine if the participant is a candidate for the Lock-In Program.

Contact the Pharmacy Unit at: **(208) 364-1829**.

1.3.5.1 Primary Care Physician (PCP)

The PCP for lock-in participants is responsible for coordination of routine medical care and making referrals to specialists as necessary. The PCP explains to the lock-In participant all procedures to follow when the office is closed or when there is an urgent or emergency situation. This coordination of care and the participant's knowledge of office procedures should help reduce the unnecessary use of the emergency room.

If the participant needs to see a physician other than the PCP, the PCP gives the participant a written referral to another physician or clinic to ensure payment. This also applies to physicians covering for the PCP and emergency rooms for non-emergency care. The referred physician must contact the PCP for the Idaho Medicaid provider number and enter it on all claims.

Note: To avoid possible abuse, the PCP provider number must not be included on the written referral.

If a PCP no longer wishes to provide services to the participant, the PCP must send a written notice to the participant stating the reasons for dismissal with a copy of the letter sent to the Health Resources Coordinator in your region.

1.3.5.2 Designated Pharmacy

A designated pharmacy has the responsibility of monitoring the participant's drug use pattern. The pharmacy should only fill prescriptions from the PCP or from referred physicians.

Note: All referrals must be confirmed with the PCP before prescriptions are dispensed.

1.4 Benefit Plan Coverage

1.4.1 Medicaid Enhanced Plan

Medicaid offers an enhanced plan to children and adults. The Medicaid Enhanced Plan includes all of the benefits found in the Medicaid Basic Plan, plus additional benefits to cover needs of people with disabilities or special health needs. Participants enrolled in this plan will be eligible for the full range of Medicaid covered services.

1.4.2 Medicaid Basic Plan

1.4.2.1 Overview

Medicaid offers a basic plan to children and adults. The Medicaid Basic Plan has been designed to achieve and maintain wellness by emphasizing prevention and proactively managing health.

1.4.2.2 Covered Services

Medical coverage under the Medicaid Basic Plan is limited with some notable differences between the Medicaid Enhanced Plan and Medicaid Basic Plan.

1.4.2.3 Excluded Services

- Drugs not covered under Medicaid.
- Rehabilitative services provided by a developmental disability (DD) facility.
- Psychosocial rehabilitation services, except when provided by school-based service providers.
- Intermediate care facility (for developmentally disabled)/mentally retarded (ICF/MR) services.
- Skilled nursing facility services.
- Nursing facility services.
- Hospice care services.
- Case management services.
- Personal care services.
- Home and community based services.
- Partial care treatment.

1.4.2.4 Restricted Services

Mental health inpatient services are limited to ten days, per calendar year whether in a hospital or freestanding facility. Freestanding facilities are limited to individuals under the age of 22.

Outpatient mental health services for certain provider specialties are limited to 26 services per calendar year, for all non-inpatient mental health services combined. See *Section 3 Provider Guidelines* for specific service coverage and limitations for individual programs and specialties.

1.4.2.5 Third Party Recovery (TPR) Requirements

All services must be billed to the participant's other insurance before billing Medicaid. See *Section 2.4 Third Party Recovery (TPR)*, for billing details.

1.4.2.6 Medical Necessity

Under some circumstances, participants in the Medicaid Basic Plan with a medical necessity for enhanced services may be eligible for reassignment to the Medicaid Enhanced Plan. This determination will be a joint decision made by the appropriate units in the Welfare (Self Reliance) and Medicaid Divisions.

1.4.2.7 Billing Procedures

Follow the same billing practices for any other Medicaid participant.

1.4.3 Presumptive Eligibility (PE)

Pregnant Women (PW): The program was developed as a result of the Federal Catastrophic Health Bill of 1988 to offer medical assistance to pregnant women. The program assists Idaho residents not currently receiving medical assistance from the state or county, and do not have sufficient resources for private medical coverage during their pregnancy. Presumptive eligibility provides immediate, presumed coverage for qualified candidates. The maximum coverage period is 45 days. During this time, the PE participant formally applies for another program offered under Medicaid. The Department of Health and Welfare (DHW) determines if the pregnant woman is qualified for the PW Program or another category of assistance. The goal of the program is to encourage pregnant women to seek prenatal care early in a pregnancy and preserve the health of both mother and infant.

Breast and Cervical Cancer: Presumptive eligibility is also available for women who have been initially screened and diagnosed through the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP).

This program allows the state to provide Medicaid benefits to uninsured women between the ages of 40 and 65 when they are in need of treatment for breast or cervical cancer, including pre-cancerous conditions and early stage cancer. Certain criteria must be met in order to qualify.

1.4.3.1 Program Procedures

The candidate seeking medical assistance for pregnancy must see an approved provider trained and certified by DHW, such as a health district or hospital. Additionally, providers qualified to perform PW PE determination must meet the eligibility criteria listed in Section 1920 of the Social Security Act.

Potential PE candidates answer preliminary program questions from the provider to determine if they are eligible for the program. These qualifications are determined by federal guidelines.

The PE candidate for the PW Program must have a medically verified pregnancy and have financial resources that fall within specific income levels. Eligibility for pregnancy services under the PE Program is determined as follows:

- Participant and provider complete program questions and determine if the participant is eligible for the PE Program.
- Participant's local field office receives the application for services from the provider, processes it, and issues a Medicaid number for participant's PE eligibility period.
- Participant's PE period ends after a maximum coverage period of 45 days or sooner if the candidate is eligible for PW or another Medicaid program.

Follow these steps to submit your claims:

1. Verify the participant's eligibility using Medicaid Automated Voice Information Service (MAVIS) or electronic software. See *Section 1.3.4 Verifying Participant Eligibility*, for instructions.
2. Submit your claim with the participant's Medicaid identification (MID) number.

The PE candidate for the Breast and Cervical Cancer Program must be screened through a local Women's Health Check Office (usually the district health department) and test positive for a breast or cervical cancerous or pre-cancerous condition that requires treatment.

1.4.3.2 Covered Services

Medical coverage for the PW Program during the PE period is restricted to ambulatory outpatient, pregnancy-related services only. Pregnancy related services may be rendered by any qualified Medicaid provider.

Routine prenatal services are covered, as well as some additional services such as nutrition counseling, risk-reduction follow-up, and social service counseling. Providers are not required to bill another insurance resource, if it exists, before billing Medicaid for prenatal services during the PE period.

Women who have PE for the Breast and Cervical Cancer Program, at the time of service, are eligible for Medicaid benefits during the PE period.

1.4.3.3 Medical Necessity

To bill PE services for the PW Program that are not clearly pregnancy-related, attach medical necessity documentation to a paper claim form explaining how the service is pregnancy-related. Services not clearly pregnancy-related will be denied, if documentation of medical necessity is not provided.

If the PE participant is referred to the hospital for lab testing or x-rays and the services are not clearly pregnancy-related, give the participant a completed PW Medical Necessity form. The participant takes this form to the next provider to establish the service as pregnancy-related. See *Appendix D; Forms*, for a copy of the Medical Necessity form (pregnancy related).

1.4.3.4 Excluded Services

The PE Program does not cover PW inpatient services. Medicaid does not pay for any type of abortion for participants on the PE Program. Also, PE participants are not covered for any delivery services. Services not covered under Medicaid are the participant's responsibility. If the PE participant has applied for the PW Program or any other Medicaid program, and is determined eligible, hospital inpatient services may be covered.

No specific services are excluded for NBCCEDP.

1.4.4 Pregnant Women (PW)

1.4.4.1 Overview

Medicaid offers extended eligibility and additional services to all women covered by Medicaid during their pregnancy and postpartum period. The PW Program is for pregnancy-related services only and is available to pregnant women who meet the eligibility requirements. This coverage ends on the last day of the month in which the 60th day after delivery occurs.

Medicaid developed the PW Program to help ensure that all women have access to prenatal and postpartum care. The ultimate goal is to ensure the health of mothers and infants.

1.4.4.2 Covered Services

Medical coverage under PW is restricted to pregnancy-related services only. Normal prenatal services are covered as well as some additional services such as nutrition counseling, risk reduction follow-up, and social service counseling. Pregnancy related services are those necessary for the health of the mother or fetus, or services that become necessary because of the pregnancy.

Chiropractic and physical therapy services for participants enrolled in the PW Program must be billed on a paper claim with attached documentation explaining the medical necessity and how the services are pregnancy related.

Dental coverage under PW is limited to the relief of pain and infection that could affect the outcome of the pregnancy. See *Section 3 Dental Guidelines*, for a description of the specific dental codes covered for women participating in the PW Program. All family planning services normally covered under Medicaid, including sterilization, are covered under the PW Program. When billing for sterilization, all appropriate consent forms must be attached, along with documentation/justification that the service was performed

during the two month post-partum period. Family planning services are only covered during the 60-day postpartum period. For example:

Delivery Date	30 Days Postpartum	60 Days Postpartum	PW Coverage Ends On
09/15/2006	10/15/2006	11/14/2006	11/30/2006
12/02/2006	01/01/2007	01/31/2007	01/31/2007

1.4.4.3 Non-Covered Services

Optical benefits are not normally covered as a part of the PW Program. A physician must provide medical necessity documentation if billing for optical services that directly affect the pregnancy or if the symptoms being treated are a direct result of the pregnancy.

1.4.4.4 Third Party Recovery (TPR) Requirements

Prenatal services, delivery, and all postpartum services must be billed to the participant's other insurance before billing Medicaid. See *Section 2.4 Third Party Recovery (TPR)*, for billing details.

1.4.4.5 Medical Necessity

If the services are not clearly pregnancy-related, attach medical necessity documentation to the paper claim to explain how the service is pregnancy-related. The information from the medical necessity documentation will be used to determine if the service provided relates to the pregnancy. It is not a guarantee that the service will be reimbursed. Services not clearly pregnancy related will be denied if documentation of medical necessity is not provided.

The EDS medical consultant reviews each claim on a case-by-case basis. EDS may deny a claim with the reason; *This PW participant's charge has been reviewed by the EDS medical consultant and denied*.

Form Available: A Medical Necessity form is included in *Appendix D; Forms*.

To request further review, write to:

Division of Medicaid
Medical Care Unit
PO Box 83720
Boise, ID 83720-0036

1.4.4.6 Excluded Services

Excluded services include treatment that is not a direct result of, or which does not directly affect the pregnancy.

1.4.4.7 Billing Procedures

Follow the same billing practices for a PW participant as for any other pregnant Medicaid participant. All services must be pregnancy-related.

1.4.5 Breast and Cervical Cancer

1.4.5.1 Program Policy

A woman not otherwise eligible for Medicaid who meets certain conditions may be eligible for Medicaid benefits for the duration of her cancer treatment.

1.4.5.2 Eligibility

In order to be eligible, the participant must be initially screened and diagnosed through a local Women's Health Check Office (usually the district health department) as a representative of the Centers for Disease Control and Prevention.

The participant can be presumed eligible before a formal Medicaid determination under PE as described in, *Section 1.4.3 Presumptive Eligibility (PE)*. Although Medicaid resource limits do not apply, the participant must:

- Meet the designated income limit.
- Be diagnosed with breast or cervical cancer through the Women's Health Check Program.
- Be at least 40 years old and under the age of 65.
- Have no credible insurance, (if insured, the plan does not cover the same type of cancer).
- Be an Idaho resident.
- Provide a valid Social Security number.
- Be a U.S. citizen or meet requirement for legal non-citizen.
- Not reside in an ineligible institution.
- Not be fleeing prosecution of a felony, custody, or confinement of a felony conviction or violating a condition of probation or parole.
- Be willing to cooperate with DHW to secure medical or child support services, unless the participant has good cause.

1.4.5.3 Covered Services

Women who qualify for this program are eligible for Medicaid benefits during the treatment phase of their cancer care.

1.4.5.4 Stages of Treatment

Coverage for primary cancer treatment may include:

- Medical and surgical services.
- Pre-cancerous conditions.
- Early stage cancer.

Adjuvant cancer treatment involving radiation or systemic chemotherapy included in the treatment plan, are also covered.

1.4.5.5 End of Treatment

Cancer treatment ends when a participant's plan of care reflects a status of surveillance, follow-up, or maintenance. Additionally, benefits will end if a participant's treatment relies on an unproven procedure in lieu of primary or adjuvant treatment methods.

1.4.6 Medicare Savings Program

1.4.6.1 Program Policy

The state has agreements with the Social Security Administration (SSA) and Centers for Medicare and Medicaid Services (CMS), which allows the state to enroll people in the Premium Hospital Insurance Program (also referred to as Premium HI or Medicare Part A) and the Supplementary Medical Insurance (also referred to as SMI or Medicare Part B). The agreements allow Medicaid participants who are entitled to Medicare to have their Part A and/or Part B Medicare premiums paid by Medicaid. Participants do not have to be 65 years old or older to be eligible for Medicare. The statutory authority for the Medicare Savings Program is §1843 of the Social Security Act and Medicare Catastrophic Act of 1988.

The purpose of these arrangements is to permit the state to provide Medicare protection to certain groups of low income and disabled individuals as part of its total assistance plan. The arrangements transfer the

partially state-funded medical costs for this population from Title XIX Medicaid Program to the Title XVIII Medicare Program, which is funded by the federal government and by payment of individual premiums. Federal Financial Participation (FFP) is available through the Medicaid Program to assist the states with the premium payment for certain groups of low income and disabled individuals.

There are two types of Part A Medicare Savings Program participation:

- Regular Type Part A.
- Qualified Disabled Working Individual (QDWI) Part A.

See *Section 2.5.5 Qualified Medicare Beneficiaries (QMB) Medicare/Medicaid Billing Information*, for more information.

1.4.6.2 Part A Medicare Savings Program

This program is for individuals that are not entitled to premium-free Medicare Part A benefits. These individuals must apply for Medicare with the Social Security Administration and be determined eligible for self-pay type Medicare.

These individuals have a Medicare claim number with a Beneficiary Identification Code (BIC) of *M*. This code is found at the end of the Medicare claim number.

Medicaid pays the Medicare Part A premium, coinsurance, and deductible only.

1.4.6.3 Qualified Disabled Working Individual (QDWI) Part A Medicare Savings Program

Qualified Disabled Working Individual Program does not include state payment of Part B Medicare premiums.

Individuals on the QDWI Program have lost Medicare Part A (HI) entitlement solely because of work, and are entitled to enroll in Part A Medicare under §1818A of the Social Security Act.

Medicaid pays the Medicare premium, coinsurance, and deductible only.

1.4.6.4 Part B Medicare Savings Program

There are several types of participation in the Part B Medicare Savings Program in Idaho:

Participation	Short Name	Description
Qualified Medicare Beneficiary	QMB	Individual is entitled to Medicare and meets the income limits. Medicaid pays the Medicare premium, and up to the lower allowed amount for the medical service (Medicare/Medicaid).
Qualified Medicare Beneficiary with Medicaid	QMB+ (QMB Plus)	Individual is entitled to Medicare, meets income limits, and has open Medicaid eligibility. Medicaid pays the Medicare premium, up to the lower allowed amount for the medical service (Medicare/Medicaid). Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.

Participation	Short Name	Description
Specified Low Income Medicare Beneficiary	SLMB	Individual is entitled to Medicare and is within income limits. Medicaid pays the Medicare premiums only.
Specified Low Income Medicare Beneficiary with Medicaid eligibility	SLMB+ (SLMB Plus)	Individual is entitled to Medicare, within income limits and on Medicaid eligibility. Medicaid pays the Medicare premium, coinsurance, and deductible. Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Medicaid (with deemed Cash Assistance Recipient)		Individual is entitled to Medicare, within income limits and on Medicaid eligibility. Medicaid pays the Medicare premium, coinsurance, and deductible. Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Medicaid – Non-Cash (also known as Medical Assistance Only)	MAO	Individual is entitled to Medicare, within income limits and on Medicaid eligibility. Medicaid pays the Medicare premium, up to the lower allowed amount for the medical service (Medicare/Medicaid). Medicaid pays for Medicaid-allowed services and supplies not covered by Medicare.
Qualified Individual 1	QI1	Individual is entitled to Medicare and within income limits. Medicaid pays the Medicare premiums only.

1.4.6.5 Medicaid Pays a Portion of the Dually Eligible Medicare Beneficiaries

Dually eligible individuals are persons who are entitled to Medicare and are eligible for Medicaid. Dually eligible individuals are eligible for Medicare and Medicaid benefits under the category of assistance programs for which they qualify. Dually eligible participants receive Medicare premium coverage and coinsurance/deductible reimbursement consideration for all Medicare covered services. Pharmacy items or other services not covered by their Medicare benefits may be covered under their Medicaid benefits. For services covered by both programs bill Medicare first.

1.4.6.6 Qualified Medicare Beneficiary (QMB)

Qualified Medicare beneficiary (QMB) participants are only eligible for Medicare paid claims, up to the lower allowed amount (Medicare/Medicaid) from Idaho Medicaid. Claims filed for Medicare's coinsurance and deductible are called, crossover claims. The Medicaid Remittance Advice (RA) shows the payment of these charges on the, Professional Crossover Claim page on the first detail line.

Submit each claim form with its own copy of the corresponding Medicare Remittance Notice (MRN) attached. All crossover claims submitted on paper must match the Medicare MRN exactly.

Submit two separate claims to Medicaid – First claim for the crossover portion and the second claim for the non-covered Medicare services when an MRN contains covered and non-covered services (for dually eligible QMB participants only). Both must have a copy of the MRN included. Indicate, *Medicare Non-Covered Benefit*, in field **19** of the CMS-1500 claim form, field **80** of the UB-04 claim form, or field **61** of the ADA claim form.

1.4.6.7 Medicare Part D

The Medicare Modernization Act was signed into law December 8, 2003. Under the law, dually eligible individuals will no longer receive their drug coverage from Medicaid and instead will select or be auto enrolled into private Medicare prescription drug plans effective January 1, 2006. Medicaid may still cover certain essential drugs excluded by law from the Medicare Part D, Prescription Drug Program. Medicare must be billed prior to submitting drug claims to Medicaid. If the Medicare Explanation of Benefits (EOB) indicates that the requested medication is one of the medications not covered by law, then Medicaid may reimburse.

1.4.7 Medicare-Medicaid Coordinated Plan (MMCP)

In the spring of 2007, Idaho Medicaid implemented a new benefit plan to support the Medicaid Modernization initiative. The benefit plan that integrates Medicare and Medicaid benefits for individuals who are dually eligible for both programs. This benefit plan, called the MMCP, will provide full dually eligible individuals the option of enrolling in an integrated benefits program offered by participating Medicare Advantage Plans.

1.4.7.1 Program Policy Overview

The MMCP includes all of the benefits found in the Medicaid Enhanced Plan and is designed for participants who are also covered under Medicare Part A and Part B, otherwise known as full dually eligible. This plan will provide full dually eligible participants the option of enrolling in an integrated benefits program offered by participating Medicare Advantage Plans. In order for a participant to sign up for a Medicare Advantage Plan, the full dually eligible participant must live in the county that the Medicare Advantage Plan serves.

1.4.7.2 Covered Services

Medicare Advantage Plans traditionally covers specific medical benefits. Medicaid will continue to cover certain services. Integrated benefits will be those benefits that Medicaid usually covers that will now be covered by the Medicare Advantage Plan. The following table distinguishes the services that the MMCP covers and what Medicaid will continue to cover.

Benefit	MMCP	Medicaid
Hospital services	X	
Outpatient services	X	
Emergency hospital services	X	
Ambulatory surgical center services	X	
Physician medical services	X	
Physician surgical services	X	
Certified pediatric or family nurse practitioner services	X	
Physician assistant services	X	
Chiropractor services	X	
Podiatrist services	X	
Optometrist services	X	

Benefit	MMCP	Medicaid
Certified nurse-midwife services	X	
Primary care case management	X	
Primary care case management: For persons with mental illness, for persons receiving personal care services, and for persons with developmental disabilities	X	
Adult physicals	X	
Service coordination: For people with mental illness, for people receiving personal care services, and people with developmental disabilities		X (Must be enrolled in the Medicaid Enhanced Plan)
Screening mammography services	X	
Prevention and health assistance benefits (includes health/wellness education and intervention services such as disease management, tobacco cessation programs, or weight management)	X	
Laboratory and radiological services	X	
Prescribed drugs under Medicare Part D	X	
Prescribed drugs not covered by Medicare Part D	X	
Family planning services	X	
Inpatient psychiatric services	X	
Outpatient mental health services	X	
Psychosocial rehabilitative services		X
Home health care	X	
Therapy services	X	
Speech, hearing, and language	X	
Medical equipment and supplies	X	
Specialized medical equipment and supplies	X	
Prosthetic devices	X	
Vision services	X	
Dental, medical, and surgical services	X	
Other dental care	X	
Rural health clinics	X	

Benefit	MMCP	Medicaid
Federally qualified health center services	**X**	
Indian health services	**X**	
Medical transportation	**X**	
Nursing facility services <= 100 days	**X**	
Nursing facility services >100 days		**X**
Personal care services		**X**
Other home and community based service providers		X
Hospice care	**X**	
Intermediate care facility services (ICF/MR)		**X**
Developmental disability agency services		**X**
Medicare advantage cost sharing (deductibles and coinsurance)	**X (included in the premium payment)**	

1.4.7.3 Participant Identification Number

Participants covered by MMCP, will continue to use the MID number as established under, *Section 1.3 Participant Eligibility*. Participating Medicare Advantage Plans offering MMCP will also issue a plan identification number specific to their company.

1.4.7.4 Billing Procedures

For participants covered by MMCP, providers may bill Medicaid for services listed below using the MID number assigned to the participant.

- Psychosocial rehabilitation services.
- Nursing facility services.
- Personal care services.
- Other home and community based services.
- Intermediate care facility (for developmentally disabled)/mentally retarded (ICF/MR) services.
- Developmental disability agency services.

For all other services, bill the appropriate MMCP vendor servicing the participant. When billing the MMCP vendor, be sure to follow the vendors billing requirements. Claims will be processed per the vendors' rules and guidelines.

1.4.8 Otherwise Ineligible Aliens (OIA)

1.4.8.1 Overview

Medicaid offers eligibility to ineligible legal or illegal non-citizens for medical services necessary to treat an emergency medical condition. An emergency medical condition exists when the condition could

reasonably be expected to seriously harm the person's health, cause serious impairment to bodily functions, or cause serious dysfunction of any body organ or part, without immediate medical attention.

1.4.8.2 Eligibility

Medicaid eligibility for OIA begins no earlier than the date the participant experiences the medical emergency and ends the date the emergency condition stops. The Division of Medicaid, Medical Care Unit determines the beginning and ending dates of eligibility.

1.4.8.3 Covered Services

Obstetrical deliveries are considered emergencies. However, antepartum and postpartum care are not considered to be emergencies. The Division of Medicaid, Medical Care Unit reviews each request for payment for OIA and determines if a medical condition is an emergency.

1.5 Healthy Connections (HC)

1.5.1 Overview

Healthy Connections (HC) helps Medicaid participants receive the care they need, when they need it, and at the appropriate place. The assurance of a familiar, consistent doctor and patient relationship creates a medical home. This is where participants receive the preventive and other basic health care needed to help promote good health.

The goals of HC are to:

- Ensure access to healthcare.
- Promote and protect the health of Medicaid participants.
- Emphasize continuity of care.
- Provide health education.
- Achieve cost efficiencies for the Idaho Medicaid Program.

Medicaid participant enrollment into HC is required in the majority of counties statewide. Individuals applying for Idaho Medicaid are asked to identify their current Primary Care Provider (PCP) or choose a HC PCP.

Providers who render services that require a referral must obtain the referral from the participant's HC PCP. Both the HC PCP and the provider to whom the referral has been made must keep documentation of the referral in the participant's file.

1.5.2 Provider Enrollment

Idaho Medicaid providers of primary care services can participate in HC by signing a Coordinated Care Provider Agreement. This is in addition to the Idaho Medicaid Provider Agreement. Coordinated Care Provider Agreements are available from the Regional Health Resources Coordinators (HRC). Addresses and telephone numbers for the regional HC offices are listed in the *Directory* of this provider handbook, as well as on our HC Web site at: **www.healthyconnections.idaho.gov**.

Healthy Connections PCPs agree to:

- Provide Primary Care Services.
- Exercise best efforts to monitor and manage the participant's care.
- Provide 24-hour telephone access to a medical professional.
- Make referrals when medically necessary services are not provided by the HC PCP.

In addition to payment for services rendered, PCPs enrolled in the HC Program are paid a monthly case management fee of $3.50 per month, for each enrolled participant. This monthly case management fee is based upon the number of HC Medicaid participants enrolled in the practice during a calendar month regardless of whether or not the participant is seen during that month.

1.5.3 Participant Enrollment

Enrollment in HC is prospective and always begins the first day of the month. Each enrolled participant is sent a written notice listing the name, phone number, and address of the HC PCP. This notice is sent prior to the effective date of the HC enrollment.

Medicaid participants may choose a HC PCP in one of the following ways:

1. Indicate their choice of HC PCP on the Application for Assistance when they apply for Medicaid.

2. Complete and return a HC Enrollment form received in the mail from the Department of Health and Welfare (DHW).
3. Complete a HC Enrollment form at the PCPs clinic. The clinic then sends the form to the regional HC office.
4. Call the regional HC office to enroll over the phone.

Family members are not required to choose the same HC PCP. If a participant requires assistance in choosing a HC PCP, the regional HRC can provide information regarding available PCPs and will assist the participant in making a selection.

Enrollment in HC is mandatory for most Medicaid participants. Exemptions from enrollment are described in *Appendix A, Healthy Connections*. When a Medicaid participant does not choose a PCP and the participant lives in a mandatory participation area, DHW assigns the participant to a HC PCP.

Participants may request a change in their HC PCP. If the HRC is notified by the 20th of any month, the change will be effective the first day of the following month. Otherwise, the change is not effective for another month.

See *Appendix A, Healthy Connections*, for additional enrollment information.

1.5.4 Referrals

1.5.4.1 Overview

If the HC PCP determines that specialized services are necessary, the PCP refers the participant to a specialist for the services. Medicaid will pay for covered services received from another Idaho Medicaid provider with a referral from the HC PCP. All services requiring a HC referral that are rendered without a referral are considered non-covered services and will not be paid by the Medicaid Program.

Prior to performing any services, all Medicaid providers should check to see if the participant is Medicaid eligible and if they are enrolled in HC. When obtaining eligibility information, the provider should also request the name and telephone number of the HC PCP in order to obtain the appropriate referral to provide services. If no HC PCP is listed, no HC referral is needed.

- All services require a referral except for those listed in *Section 1.5.4.5 Services Not Requiring a Healthy Connections (HC) Primary Care Provider (PCP) Referral*.
- All services requiring a HC PCP referral that are provided without a referral are considered non-covered services. A provider rendering non-covered services must advise the participant (preferably in writing) prior to providing such services.

1.5.4.2 Method of Referral

A referral is a doctor's order for services. Healthy Connections (HC) PCPs can make a referral for a participant by:

- Filling out a referral form and giving it to the participant (to take with them to the specialist) or sending it directly to the specialist.
- Ordering services on a prescription pad.
- Calling orders to the specialist.

1.5.4.3 Documentation of Referrals

Both the HC PCP and the provider being referred to must document the specifics of the referral in the participant's file. If the HC PCP has completed a referral form, a copy of the form should reside in the participant's file in both providers' offices. If another form of physician order or referral was used, such as a phone call or standing order, this information is also required to be in the participant's files and should include specifics of the referral or physician order.

Use of a HC PCP referral number indicates that the billing provider has obtained and documented the referral in the participant's record.

Note: Using a referral number without obtaining a referral is fraudulent.

The details of the referral are to be documented in the participant's permanent record by both the referring provider and the provider to whom the referral was made. The record should include:

- Who made the referral.
- Date of referral.
- Scope of services to be provided (including authorization for the receiving providers to use the HC PCP referral number to refer the participant to additional, related ancillary services).
- Referral number (for billing purposes).
- Duration of the referral.

1.5.4.4 Scope of Services Authorized

The scope of services authorized by a referral is determined by the HC PCP and defines the limitations of the referral. The following are examples:

- Number of visits authorized (*e.g.*, ten physical therapy visits).
- Time limited (*e.g.*, treat for three months).
- Diagnosis or condition related (*e.g*, treat for developmental delay).

Questions regarding the scope of a referral should be directed to the HC PCP.

If a HC PCP routinely refers a participant to one specialty provider the PCP can authorize a standing order. A standing order is subject to the same information and documentation requirements as any other referral. The maximum duration of a HC referral or standing order is one year.

The HC PCP may authorize the specialist receiving a referral to order additional services on behalf of the PCP. For example, a referral to diagnose and treat authorizes the specialist to order tests to accomplish diagnosis and perform surgery, if necessary. In these cases, the specialist is to forward the referral information (including the referral number) to the service providers who need it (*e.g.,* hospital or ambulatory surgical center).

Developmental disabilities and mental health services delivered under a plan of care also require a referral from the HC PCP, in addition to any other program prior authorization (PA) requirements. The services must be a covered benefit of the participant's benefit plan. The Department of Health and Welfare staff or designated delegates overseeing service delivery are authorized to forward appropriate referral information to the various providers for service indicated in the approved plan of care.

Specialists or providers who receive HC PCP referrals are to report findings and progress back to the HC PCP unless the HC PCP indicates they do not want to receive such feedback.

1.5.4.5 Services Not Requiring a Healthy Connections Primary Care Provider (PCP) Referral

The following services do not require a referral by the PCP. Services must be a covered service under the participant's benefit plan. If the service is not on this list, it must have a referral:

Anesthesiology Services.

Audiology Services: Performed in the office of a certified audiologist. Audiology basic testing requires a physician's order not necessarily from the PCP.

Chiropractic Services: Performed in the office, Medicaid will pay for a total of 24 manipulations during any calendar year for the treatment of misalignment of the spine (subluxation).

Dental Services: All dental services are exempt from referral. Pre-operative examinations for procedures performed in an inpatient-outpatient hospital setting or ambulatory surgical center setting should be performed by the PCP when possible. Otherwise, the exam requires a referral. Dental procedures may require PA.

Emergency Department: Services provided in an emergency department of a hospital.

Family Planning Services: Provided by district health departments or other agencies providing counseling and supplies to prevent pregnancy.

Immunizations: Immunizations do not require a referral when they do not require an office visit. Specialty physician and providers administering immunizations are asked to provide the participant's PCP with immunization records to assure continuity of care and avoid duplication of services.

Intermediate Care Facility (for Developmentally Disabled)/ Mentally Retarded (ICF/MR) Services: (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)

Indian Health Clinic Services.

Influenza Shots.

Laboratory Services (includes pathology).

Nursing Facility Services: (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)

Personal Care Services (PCS): (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)

PCS Case Management: (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)

Pharmacy Services: For prescription drugs only.

Podiatry Services: Performed in the office, however, procedures performed in an inpatient or outpatient hospital or ambulatory surgery center require a referral from the PCP for the facility and ancillary physicians and providers such as anesthesiologists, pathologists, radiologists, pre-operative exam by a physician, and lab work.

Radiology Services.

School District Services: Includes all health related services provided by a school district under an Individual Education Plan (IEP).

Screening Mammography: Limited to one per calendar year, for women age 40 or older.

Sexually Transmitted Disease Testing.

Transportation Services.

Vision Services: Performed in the offices of ophthalmologists and optometrists, including eyeglasses. Procedures performed in an inpatient or outpatient hospital or ambulatory surgery center require a referral from the PCP for the facility. A HC referral is also required for the pre-operative exam if not performed by the PCP. The PCP should perform the pre-operative exam whenever possible.

Waiver Services for the Aged and Disabled or Traumatic Brain Injury: (**Note:** These services are only covered for Medicaid Enhanced Plan participants.)

1.5.4.6 Reimbursement for Services Requiring Referral

When a PCP refers a participant to another provider or institution, the receiving provider or institution must do one of the following to receive reimbursement:

- List the referring PCP's HC referral number in field **78** or **79** of the UB-04 claim form.
- Enter the PCP's name in field **17** and their HC referral number in field **17A** of the CMS-1500 claim form.
- Enter the information in the appropriate fields for electronic submissions. See the *Provider Electronic Solutions (PES) Handbook* if using PES software.

Use of a PCP's HC referral number indicates that the billing provider has obtained and documented the referral in the participant's record.

Note: Using a referral number without obtaining a referral is fraudulent.

1.5.4.7 Program Liaison

The HC Program provides staff to help you resolve program related problems you may encounter. Please contact your local HRC to obtain information, training, or to answer questions. Refer to the *Directory* for specific contact information.

1.6 Child Wellness Exams

1.6.1 Wellness Exams

All children ages birth through 21 should receive regular wellness exams from their Primary Care Provider (PCP). Idaho Medicaid has adopted the American Academy of Pediatrics (AAP) periodicity schedule as the recommended frequency for child wellness exams. This periodicity schedule has been replicated in the tables found in *Section 1.6.4 Periodicity Schedule*.

Parents are sent reminder notices to schedule wellness exams for their child(ren).

1.6.2 Content of Wellness Exams

The AAP periodicity schedule delineates the types of screening and testing for each age group that should be conducted during a wellness exam. Federal law requires that the wellness exam be comprised of:

- Comprehensive health and developmental history.
- Comprehensive unclothed physical exam.
- Appropriate immunizations.
- Laboratory tests (as indicated in periodicity schedule).
- Health education including anticipatory guidance.

Note: Federal regulations require that all Medicaid eligible children are tested for lead poisoning at the age of 12 and 24 months.

1.6.3 Periodicity Schedule

If a child receives care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.

Note: Medicaid eligible children should be tested for lead poisoning at least once prior to age six if required testing was not completed at 12 and 24 months.

1.6.3.1 Infancy Screening

Age [1]	Newborn[2,3]	3-5[4] Days	By 1 Mo	2 Mos	4 Mos	6 Mos	9 Mos
History							
Initial/Interval	X	X	X	X	X	X	X
Measurements							
Length/Height and Weight	X	X	X	X	X	X	X
Head Circumference	X	X	X	X	X	X	X
Weight for Length	X	X	X	X	X	X	X
Blood Pressure[5]	R	R	R	R	R	R	R
Sensory Screening							
Vision	R	R	R	R	R	R	R
Hearing	X[7]	R	R	R	R	R	R
Development/Behavior Assessment							
Developmental Screening[8]							X
Developmental Surveillance[8]	X	X	X	X	X	X	
Psychosocial/Behavioral Assessment	X	X	X	X	X	X	X
Physical Examination[10]	X	X	X	X	X	X	X
Procedures[11]							
Newborn Metabolic Screening[12]	←	X	→	→			
Immunization[13]	X	X	X	X	X	X	X
Hematocrit or Hemoglobin[14]					R		
Lead Screening[15]						R	R
Tuberculin Test[17]			R			R	
Oral Health[21]						R	R
Anticipatory Guidance[23]	X	X	X	X	X	X	X

Key: **X** = To be performed.

R = Risk assessment to be performed with appropriate action to follow, if positive

← **or** → = The range during which a service should be provided (with the X at the preferred age).

Notes: 1 - 23 are found in *Section 1.6.4.5, Notes from the Recommendations for Preventive Pediatric Health Care the American Academy of Pediatrics (AAP)*.

Anticipatory Guidance during Infancy (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
Newborn	Family Readiness, Infant Behaviors, Feeding, Safety, Routine Baby Care
First Week	Parental (Maternal) Well-Being, Newborn Transition, Nutritional Adequacy, Safety, Newborn Care
1 Month	Parental (Maternal) Well-Being, Family Adjustment, Infant Adjustment, Feeding Routines, Safety
2 Month	Parental (Maternal) Well-Being, Infant Behavior, Infant-Family Synchrony, Nutritional Adequacy, Safety
4 Month	Family Functioning, Infant Development, Nutrition Adequacy and Growth, Oral Health, Safety
6 Month	Family Functioning, Infant Development, Nutrition and Feeding: Adequacy/Growth, Oral Health, Safety
9 Month	Family Adaptations, Infant Independence, Feeding Routine, Safety

1.6.3.2 Early Childhood Screening

Age[1]	12 Mos	15 Mos	18 Mos	24 Mos	30 Mos	3 Yrs	4 Yrs
History							
Initial/Interval	X	X	X	X	X	X	X
Measurements							
Length/Height and Weight	X	X	X	X	X	X	X
Head Circumference	X	X	X	X			
Weight for Length	X	X	X				
Body Mass Index				X	X	X	X
Blood Pressure[15]		R	R	R	R	X	X
Sensory Screening							
Vision	R	R	R	R	R	X[6]	X
Hearing	R	R	R	R	R	R	X
Developmental/Behavioral Assessment							
Developmental Screening[8]			X		X		
Autism Screening[9]			X	X			
Developmental Surveillance[8]	X	X		X		X	X
Psychosocial/Behavioral Assessment	X	X	X	X	X	X	X
Physical Examination[10]	X	X	X	X	X	X	X
Procedures[11]							
Immunization[13]	X	X	X	X	X	X	X
Hematocrit or Hemoglobin[14]	X		R	R		R	R
Lead Screening[15]	X[16]		R	X[16]		R	R
Tuberculin Test[17]	R		R	R		R	R
Dyslipidemia Screening[18]				R			R

Age[1]	12 Mos	15 Mos	18 Mos	24 Mos	30 Mos	3 Yrs	4 Yrs
Oral Health[21]	X or R[21]		X or R[21]	X or R[21]	X or R[21]	X[22]	
Anticipatory Guidance	X	X	X	X	X	X	X

Key: **X** = To be performed.

R = Risk assessment to be performed with appropriate action to follow, if positive

← **or** → = The range during which a service should be provided (with the X at the preferred age).

Notes: 1 - 23 are found in, *Section 1.6.4.5, Notes from the Recommendations for Preventive Pediatric Health Care the American Academy of Pediatrics (AAP)*.

Anticipatory Guidance during Early Childhood (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
12 Month	Family Support, Establishing Routines, Feeding and Appetite Changes, Establishing a Dental Home, Safety
15 Month	Communication and Social Development, Sleep routines and Issues, Temper Tantrums and Discipline, Healthy Teeth, Safety
18 Month	Family Support, Child Development and Behavior, Language Promotion/Hearing, Toilet Training Readiness, Safety
24 Month	Assessment of Language Development, Temperament and Behavior, Toilet Training, Television Viewing, Safety
30 Month	Family Routines, Language Promotion and Communication, Promoting Social Development, Preschool Considerations, Safety
3 Year	Family Support, Encouraging Literacy Activities, Playing with Peers, Promoting Physical Activity, Safety
4 Year	School Readiness, Developing Healthy Personal Habits, Television/Media, Child and Family Involvement and Safety in the Community, Safety

1.6.3.3 Middle Childhood Screening

Age[1]	5 Yrs	6 Yrs	7 Yrs	8 Yrs	9 Yrs	10 Yrs
History						
Initial/Interval	X	X	X	X	X	X
Measurements						
Height and Weight	X	X	X	X	X	X
Body Mass Index	X	X	X	X	X	X
Blood Pressure[5]	X	X	X	X	X	X
Sensory Screening						
Vision	X	X	R	X	R	X
Hearing	X	X	R	X	R	X
Developmental/Behavioral Assessment						
Developmental Surveillance[8]	X	X	X	X	X	X
Psychosocial/Behavioral Assessment	X	X	X	X	X	X
Physical Examination[10]	X	X	X	X	X	X
Procedures[11]						
Immunization[13]	X	X	X	X	X	X
Hematocrit or Hemoglobin[14]	R	R	R	R	R	R
Lead Screening[15]	R	R				
Tuberculin Test[17]	R	R	R	R	R	R
Dyslipidemia Screening[18]		R		R		R
Oral Health[21]		X[22]				
Anticipatory Guidance[23]	X	X	X	X	X	X

Key: **X** = To be performed.

R = Risk, performed for patients at risk.

← **or** → = The range during which a service should be provided (with the X at the preferred age).

Notes: 1 - 23 are found in, *Section 1.6.4.5 Notes from the Recommendations for Preventive Pediatric Health Care the American Academy of Pediatrics (AAP)*.

Anticipatory Guidance during Middle Childhood (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
5 & 6 Year	• School Readiness • Mental Health • Nutrition and Physical Activity • Oral Health • Safety
7, 8, 9 & 10 Year	• School • Development and Mental Health • Nutrition and Physical Activity • Oral Health • Safety

1.6.3.4 Adolescence Screening

Age[1]	11 Yrs	12 Yr	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs	21 Yrs
History											
Initial/Interval	X	X	X	X	X	X	X	X	X	X	X
Measurements											
Height and Weight	X	X	X	X	X	X	X	X	X	X	X
Body Mass Index	X	X	X	X	X	X	X	X	X	X	X
Blood Pressure[5]	X	X	X	X	X	X	X	X	X	X	X
Sensory Screening											
Vision	R	X	R	R	X	R	R	X	R	R	R
Hearing	R	R	R	R	R	R	R	R	R	R	R
Developmental/ Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X
Developmental Surveillance[8]	X	X	X	X	X	X	X	X	X	X	X
Psychosocial/Behavioral Assessment	X	X	X	X	X	X	X	X	X	X	X
Alcohol and Drug Use Assessment	R	R	R	R	R	R	R	R	R	R	R
Physical Examination[10]	X	X	X	X	X	X	X	X	X	X	X
Procedures[11]											
Immunization[13]	X	X	X	X	X	X	X	X	X	X	X
Hematocrit or Hemoglobin[14]	R	R	R	R	R	R	R	R	R	R	R
Tuberculin Test[17]	R	R	R	R	R	R	R	R	R	R	R
Dyslipidemia Screening[18]	R	R	R	R	R	R	R	←	←	X	→
STI Screening[19]	R	R	R	R	R	R	R	R	R	R	R

Age[1]	11 Yrs	12 Yr	13 Yrs	14 Yrs	15 Yrs	16 Yrs	17 Yrs	18 Yrs	19 Yrs	20 Yrs	21 Yrs
Cervical Dysplasia Screening[20]	R	R	R	R	R	R	R	R	R	R	R
Anticipatory Guidance[23]	X	X	X	X	X	X	X	X	X	X	X

Key: **X** = To be performed.

R = Risk, performed for patients at risk.

← **or** → = The range during which a service should be provided (with the X at the preferred age).

Notes: 1 - 23 are found in, *Section 1.6.4.5, Notes from the Recommendations for Preventive Pediatric Health Care the American Academy of Pediatrics (AAP)*.

Anticipatory Guidance during Adolescence (extracted from "Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents"	
Each Year Age 11-21	• Physical Growth and Development • Social and Academic Competence • Emotional Well-Being • Risk Reduction • Violence and Injury Prevention

1.6.3.5 Notes from the Recommendations for Preventive Pediatrics Health Care, the American Academy of Pediatrics (AAP)

1. If a child comes under care for the first time at any point on the schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
2. A prenatal visit is recommended for parents who are at high risk, for first-time parents, and for those who request a conference. The prenatal visit should include anticipatory guidance, pertinent medical history, and a discussion of benefits of breastfeeding and planned method of feeding per AAP statement, *The Prenatal Visit* (2001).[URL: http://aappolicy.aappublications.org/cgl/content/full/pediatrics;107/6/1434].
3. Every infant should have a newborn evaluation after birth, breastfeeding encouraged and instruction and support offered.
4. Every infant should have an evaluation within 3-5 days of birth and within 48 to 72 hours after discharge from the hospital, to include evaluation for feeding and jaundice. Breastfeeding infants should receive formal breastfeeding evaluation, encouragement, and instruction as recommended in AAP statement, *Breastfeeding and the Use of Human Milk* (2005). [URL: **http://aappolicy/aappublications.org/cgi/content/full/pediatrics;115/2/496]**. For newborns discharged in less than 48 hours after delivery, the infant must be examined within 48 hours of discharge per AAP statement, *Hospital Stay for Healthy Term Newborns* (2004), [URL http://aappolicy/aappublications.org/cgi/content/full/pediatrics;113/5/1434].
5. Blood pressure measurement in infants and children with specific risk conditions should be performed at visits before age 3 years.
6. If the patient is uncooperative, rescreen within six months per the AAP statement, *Eye Examination in Infants, Children, and Young Adults by Pediatricians* (2007) [URL: **http://aappolicy/aappublications.org/cgi/content/full/pediatrics;111/4/902**].
7. All newborns should be screened per AAP statement, *Year 2000 Position Statement: Principles and Guidelines for Early Hearing Detection and Intervention Programs* (2000) [URL: **http://aappolicy/aappublications.org/cgi/content/full/pediatrics;106/4/798**]. Joint Committee on Infant Hearing, Year 2007 position statement: principles and guidelines for early hearing detection and intervention programs. *Pediatrics.* 2007;120:898-921.
8. AAP Council on Children With Disabilities, AAP Section on Developmental Behavioral Pediatrics, AAP Bright Futures Steering Committee, AAP Medical Home Initiatives for Children With Special Needs Project Advisory Committee. Identifying infants and young children with developmental disorders in the medical home: an algorithm for developmental surveillance and screening. *Pediatrics* 2006; 118:405-420 [URL: **http://aappolicy/aappublications.org/cgi/content/full/118/1/405**].
9. Gupta VA, Hyman SL, Johnson CP; et al. Identifying children with autism early? *Pediatrics.* 2007; 119:152-153 [URL: **http://aappolicy/aappublications.org/cgi/content/full/119/1/152**].
10. At each visit, age-appropriate physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
11. These may be modified, depending upon entry point into the schedule and individual need.
12. Newborn metabolic and hemoglobinopathy screening should be done according to state law. Results should be reviewed at visits and appropriate retesting or referral done as needed.
13. Schedule(s) per the Committee on Infectious Diseases, published annually in the January edition of *Pediatrics*. Every visit should be an opportunity to update and complete a child's immunization.
14. See AAP *Pediatric Nutrition Handbook,* 5th Edition (2003) for a discussion of universal and selective screening options. See also Recommendations to prevent and control iron deficiency in the United State, MMWR. 1998;47(RR-3):1-36.

15. For children at risk of lead exposure, consult the AAP statement *Lead Exposure in Children: Prevention, Detection, and Management* (2005) [URL: **http://aappolicy/aappublications.org/cgi/content/full/116/4/1036**]. Additionally, screening should be done in accordance with state law where applicable.
16. Perform risk assessment or screens as appropriate, based on universal screening requirements for patients with Medicaid or high prevalence areas.
17. Tuberculosis testing per recommendations of the Committee on Infectious Diseases, published in the current edition of *Red Book: Report of the Committee on Infectious Diseases*. Testing should be done on recognition of high-risk factors.
18. *Third Report of the national Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report* (2002) [URL: http//circ.ahajournals.org/cgi/content/full/106/25/3143] and *The Expert Committee Recommendations on the Assessment, prevention, and Treatment of Child and Adolescent Overweight and Obesity.* Supplement to *Pediatrics.* In press.
19. All sexually active patients should be screened annually for sexually transmitted infections (STIs).
20. All sexually active girls should have screening for cervical dysplasia as part of a pelvic examination beginning within 3 years of onset of sexual activity or age 21 (whichever comes first).
21. Referral to a dental home, if available. Otherwise, administer oral health risk assessment. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
22. At the visits for 3 years and 6 years of age, it should be determined whether the patient has a dental home. If the patient does not have a dental home, a referral should be made to one. If the primary water source is deficient in fluoride, consider oral fluoride supplementation.
23. Refer to the specific guidance by age as listed in Bright Futures Guidelines (Hagan JF, Shaw JS, Doncan PM, eds. *Bright Futures: Guidelines for health Supervision of Infants, Children, and Adolescents.* 3rd ed. Elk Grove Village, IL: American Academy of Pediatrics; 2008)

1.6.4 Early & Periodic Screening, Diagnosis & Treatment (EPSDT)

Under EPSDT, children are specifically to receive:

- Wellness exams.
- Vision services, including eyeglasses.
- Dental services, including a referral to a dentist by age three.
- Hearing services, including hearing aids.

The EPSDT benefit was designed to help ensure that all Medicaid-eligible children receive preventive health care and early intervention services needed to maximize each child's potential for healthy growth and development. The benefits also allow children to receive some additional services that are not covered for adults.

1.6.5 Diagnosis

When a wellness exam indicates the need for further evaluation of a child's health, a referral should be made to the appropriate service provider if the PCP is unable to provide the diagnostic services required.

1.6.6 Treatment

Treatment needed to correct or improve defects, physical and mental illness, or other conditions discovered during a wellness exam must be provided by either the PCP or via referral to an appropriate service provider.

Medically necessary services in excess of the service limitations may be covered for child participants. All such services must be prior authorized by the Department of Health and Welfare (DHW).

1.6.7 Billing

Wellness exams must be billed with the Preventive Medicine CPT Codes, and, if applicable, a modifier. These CPT codes can be used to bill for preschool, school, summer camp, Special Olympics, or sports physicals.

The CPT codes **96110** or **96111** should be billed when using a standardized tool (such as the Ages & Stages Questionnaire) to assess development and behavior.

1.6.7.1 Diagnosis Codes

Use diagnosis code **V20.1** - Other Healthy Infant/Child, or **V20.2** - Routine Infant or Child Health Check, for all child Modifiers

Modifier	Modifier Description
U6	Patient is referred to another provider.
EP	Service provided as part of EPSDT.
25	(Description change only): Significant, separately identifiable evaluation and management service by the same physician, on the same day of the procedure, or other service.